DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAY 1 2003

TO: Thomas A. Scully
Administrator
Centers for Medicare and Medicaid Services

FROM: Dennis J. Duquette
Acting Principal Deputy Inspector General

SUBJECT: Review of Medicaid Disproportionate Share Hospital Payments Made by Virginia's Department of Medical Assistance Services to the University of Virginia Medical Center for the Fiscal Years Ending June 30, 1997 and June 30, 1998 (A-03-01-00226)

This memorandum is to alert you to the issuance of the subject audit report within 5 business days from the date of this memorandum. A copy of the report is attached. The review was conducted at the request of the Centers for Medicare and Medicaid Services (CMS) as part of a multi-state initiative focusing on Medicaid disproportionate share hospital (DSH) payments made under section 1923 of the Social Security Act (the Act).

The objectives of our review were to determine if DSH payments made by the Virginia Department of Medical Assistance Services (DMAS) to the University of Virginia (UVA) Medical Center for state fiscal years (SFY) 1997 and 1998 (1) were calculated in accordance with the approved Medicaid state plan (state plan) and (2) did not exceed the hospital's uncompensated care costs (UCC) as imposed by the Omnibus Budget Reconciliation Act of 1993.

Our audit found that DMAS made $51 million in DSH payments to UVA Medical Center for SFY 1997 and $54 million for SFY 1998. The DSH payments were calculated in accordance with the state plan. The UVA Medical Center calculated UCC of $58 million and $56 million for SFYs 1997 and 1998.

We believe UVA Medical Center overstated its UCC by including costs that were not consistent with the apparent purpose of section 1923 of the Act. We identified unallowable costs included in UCC totaling $10 million for SFY 1997 and $9 million for SFY 1998. Unallowable costs consisted of physician practice plan costs incurred by a related entity. As a result, DSH payments for SFYs 1997 and 1998 exceeded UCC by $2.8 million ($1.5 million federal share) and $6.4 million ($3.3 million federal share), respectively.

We also were unable to determine the reasonableness of UCC totaling $47 million for SFY 1997 and $44 million for SFY 1998 because we do not believe UVA Medical Center's methodology used to calculate the costs resulted in an accurate estimate of uninsured costs. The UVA Medical Center included in UCC related to services provided in prior periods.

We recommended that DMAS:

1. Refund $4,760,385 to the Federal Government for the federal share of DSH overpayments that resulted from unallowable physician practice plan costs included in UCC for SFYs 1997 and 1998.

2. Require UVA Medical Center to revise its methodology for computing UCC to exclude physician practice plan costs and to include only the net costs to treat patients admitted without insurance in the year for which the DSH payment is made.

In its limited response, DMAS disagreed with our findings. The UVA Medical Center provided a lengthy response strongly disagreeing with our findings and recommendations. The UVA Medical Center's response also challenged the Office of Inspector General's (OIG) authority for questioning the physician practice plan costs while arguing that congressional intent, a lack of CMS regulations, a broad interpretation of the state plan, and the application of Medicare cost principles support the inclusion of these costs in the UCC calculation. The UVA Medical Center also believed its methodology for estimating uninsured patient costs was reasonable while acknowledging that they have the capability to conform to our recommendation. We summarized DMAS and UVA Medical Center's comments and included the OIG's response to those comments in a separate section of the attached copy of the report. We have also appended these comments to the report.

Any questions or comments on any aspect of this memorandum are welcome. Please address them to George M. Reeb, Assistant Inspector General for the Centers for Medicare and Medicaid Audits at (410) 786-7104 or Stephen Virbitsky, Regional Inspector General for Audit Services, Region III, at (215) 861-4470.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
OFFICE OF AUDIT SERVICES
150 S. INDEPENDENCE MALL WEST
SUITE 316
PHILADELPHIA, PENNSYLVANIA 19106-3499

MAY - 5 2003

Report Number A-03-01-00226

Mr. Patrick W. Finnerty
Director
Department of Medical Assistance Services
Commonwealth of Virginia
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Dear Mr. Finnerty:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) final report entitled, **REVIEW OF MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS MADE BY VIRGINIA'S DEPARTMENT OF MEDICAL ASSISTANCE SERVICES TO THE UNIVERSITY OF VIRGINIA MEDICAL CENTER FOR THE FISCAL YEARS ENDING JUNE 30, 1997 AND JUNE 30, 1998.** A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231) OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise (see 45 CFR part 5). As such, within 10 business days after the final report is issued, it will be posted on the Internet at http://oig.hhs.gov.

To facilitate identification please refer to report number A-03-01-00226 in all correspondence relating to this report.

Sincerely,

Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Ms. Sonia A. Madison
Regional Administrator
Centers for Medicare and Medicaid Services, Region III
The Public Ledger Building
150 S. Independence Mall West, Suite 216
Philadelphia, Pennsylvania 19106-3499

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

REVIEW OF MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS MADE BY VIRGINIA'S DEPARTMENT OF MEDICAL ASSISTANCE SERVICES TO THE UNIVERSITY OF VIRGINIA MEDICAL CENTER FOR THE FISCAL YEARS ENDING JUNE 30, 1997 AND JUNE30, 1998

JANET REHNQUIST
Inspector General

MAY 2003
A-03-01-00226

EXECUTIVE SUMMARY

Background

Section 13621 of the Omnibus Budget Reconciliation Act (OBRA) of 1993 amended section 1923 of the Social Security Act (the Act) to limit disproportionate share hospital (DSH) payments. For state fiscal years (SFY) beginning after January 1, 1995, DSH payments to hospitals were limited to their uncompensated care costs (UCC). The UCC were defined as costs of services to Medicaid patients, less the amount paid by the state under the non-DSH payment provisions; plus cost of uninsured patients, less any cash payments received from those patients.

The Department of Medical Assistance Services (DMAS) administers the Medicaid program in Virginia and is responsible for DSH payments. The University of Virginia (UVA) Medical Center provides inpatient and outpatient services to patients in the Charlottesville, Virginia area.

Objectives

The objectives of our review were to determine if DSH payments to the UVA Medical Center for SFYs 1997 and 1998 (1) were calculated in accordance with the approved Medicaid state plan (state plan) and (2) did not exceed UCC as imposed by OBRA of 1993.

Summary of Findings

The DMAS made $51 million in DSH payments to the UVA Medical Center for SFY 1997 and $54 million for SFY 1998. The DSH payments were calculated in accordance with the state plan. The UVA Medical Center claimed UCC of $58 million and $56 million for SFYs 1997 and 1998. However, we found that the UVA Medical Center overstated its UCC by including costs that were not consistent with the apparent purpose of section 1923 of the Act. Unallowable costs included in UCC totaled $10 million for SFY 1997 and $9 million for SFY 1998. Unallowable costs consisted of physician practice plan costs incurred by a related entity. As a result, DSH payments for SFYs 1997 and 1998 exceeded UCC by $2.8 million ($1.5 million federal share) and $6.4 million ($3.3 million federal share), respectively.

We also were unable to determine the reasonableness of UCC totaling $47 million for SFY 1997 and $44 million for SFY 1998 because we do not believe that UVA Medical Center's methodology used to calculate the costs resulted in an accurate estimate of uninsured costs. The UVA Medical Center included in UCC costs related to services provided in prior periods.

Recommendations

We recommended that DMAS:

1. Refund $4,760,385 to the Federal Government for the federal share of DSH overpayments that resulted from unallowable physician practice plan costs included in UCC for SFYs 1997 and 1998.

2. Require UVA Medical Center to revise its methodology for computing UCC to exclude physician practice plan costs and to include only the net costs to treat patients admitted without insurance in the year for which the DSH payment is made.

Synopsis of DMAS and UVA Medical Center Responses

In its limited response, DMAS disagreed with our findings and concurred with the UVA Medical Center's methodology for calculating its UCC. The UVA Medical Center provided a lengthy response strongly disagreeing with our findings and recommendations. The UVA Medical Center's response also challenged the Office of Inspector General's (OIG) authority for questioning the physician practice plan costs while arguing that congressional intent, a lack of CMS regulations, a broad interpretation of the state plan, and the application of Medicare cost principles support the inclusion of these costs in the UCC calculation. The UVA Medical Center also believed its methodology for estimating uninsured patient costs was reasonable while acknowledging that they have the capability to conform to our recommendation.

We continue to believe that the apparent purpose of section 1923 of the Act was to limit UCC to costs incurred for services provided by hospitals. The amounts UVA Medical Center included in its UCC for physician practice plan costs were not hospital incurred costs, but instead represented costs incurred by Medical College of Virginia Physicians, a related but separate entity. Where appropriate, we made changes in the report to reflect the DMAS and UVA Medical Center comments. We included the comments in APPENDIX C. The DMAS and UVA Medical Center comments and OIG response are summarized in the report.

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INTRODUCTION

BACKGROUND

Title XIX of the Social Security Act (Act) authorizes federal grants to states for Medicaid programs that provide medical assistance to qualified low-income needy people. Each state Medicaid program is administered by the state in accordance with an approved state plan. While the state has considerable flexibility in designing its state plan and operating its Medicaid program, it must comply with broad federal requirements. At the federal level, the program is administered by the Centers for Medicare and Medicaid Services (CMS), an agency of the Department of Health and Human Services. In Virginia, the Department of Medical Assistance Services (DMAS) administers the Medicaid program and is responsible for disproportionate share hospital (DSH) payments.

The Federal Government and states share in the cost of the program. States incur expenditures for medical assistance payments to medical providers who furnish care and services to Medicaid beneficiaries. The Federal Government pays its share of medical assistance expenditures according to a defined formula. That share is known as the federal medical assistance percentage (FMAP) and ranges from 50 percent to 83 percent, depending upon each state's relative per capita income. The FMAP rate in Virginia is about 52 percent. The federal payment for its share of medical cost is referred to as federal financial participation (FFP).

The Omnibus Budget Reconciliation Act (OBRA) of 1981established the DSH program by adding section 1923 to the Act. Section 1923 required state Medicaid agencies to make additional payments to hospitals serving disproportionate numbers of low-income patients with special needs. States had considerable flexibility to define DSH hospitals under sections 1923(a) and (b) of the Act. States receive allocations of DSH funds as set forth by federal statute. The DSH expenditures are eligible for FFP. Subject to state allocations, the Federal Government reimburses states for DSH expenditures based upon the applicable Medicaid matching percentage. States report Medicaid expenditures on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64).

The OBRA of 1993 established additional DSH parameters by amending section 1923 of the Act to limit DSH payments to the amount of a hospital's incurred uncompensated care costs (UCC). Under section 1923(g), the UCC was limited to the costs of medical services provided to Medicaid and uninsured patients less payments received for those patients excluding Medicaid DSH payments. The specific language contained in the Act, as amended, is as follows:

> "Section 1923...
> (g) Limit on Amount of Payment to Hospital.---
> (1) Amount of Adjustment subject to uncompensated costs.---

(A) In General---A payment adjustment during a fiscal year shall not be considered to be consistent with...respect to a hospital if the payment adjustment exceeds the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year."

For state fiscal years (SFY) beginning between July 1, 1994 and January 1, 1995, payments to public hospitals were limited to 100 percent of UCC with a special provision that allowed payments of up to 200 percent of UCC to those public hospitals qualifying as high DSH hospitals. For SFYs beginning on or after January 1, 1995, payments to all hospitals were limited to 100 percent of UCC.

According to the Virginia state plan, DSH payments are calculated using a formula based on the type of hospital--Type One or Type Two--and the hospital's Medicaid utilization percentage. Type One consists of the two state-owned teaching hospitals, the University of Virginia (UVA) Medical Center and the Medical College of Virginia Hospitals; Type Two includes all other hospitals. Under the state plan's DSH payment formula a Type One hospital would receive about 13 times more in DSH payments than a Type Two hospital would receive for serving the same volume of Medicaid patients. The state plan also limits DSH payments to a hospital's UCC as established by OBRA of 1993. Specifically, the state plan states:

"A payment adjustment during a fiscal year shall not exceed the sum of:
(a) Medicaid allowable costs incurred during the year less Medicaid payments, net of disproportionate share payment adjustments, for services provided during the year, and
(b) Costs incurred in serving persons who have no insurance less payments received from those patients or from a third party on behalf of those patients...."

Located in Charlottesville, Virginia, the UVA Medical Center is an integrated network of primary and specialty care. The UVA Medical Center includes a 528-bed teaching hospital complemented by several clinics on the UVA campus. The UVA Medical Center is a division of UVA and is part of the UVA Health System.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of our review were to determine if DSH payments made to the UVA Medical Center for SFYs 1997 and 1998 (1) were calculated in accordance with the approved state plan and (2) did not exceed the UCC as imposed by OBRA of 1993.

To accomplish our first objective, we reviewed DSH payment data at DMAS and reconciled DSH payments to amounts claimed on Form CMS-64. For each SFY reviewed, DMAS made DSH payments to eligible hospitals over several years. Therefore, we reconciled and matched DSH payments to the SFY to which they pertained. For example, for SFY 1997, DMAS made $51,409,017 in DSH payments to the UVA Medical Center from September 26, 1996 through December 1, 2000. For SFY 1998 DMAS made $53,790,619 in DSH payments to the UVA Medical Center from September 18, 1997 through July 12, 1999. Finally, we compared DSH payments to UVA Medical Center's claimed UCC to determine whether DMAS computed DSH payments in accordance with the state plan.

To accomplish our second objective, we obtained and evaluated supporting documentation for selected categories of UVA Medical Center's claimed UCC for each SFY. The UVA Medical Center claimed UCC of $58,876,753 and $56,203,046 in SFYs 1997 and 1998. Documentation included the UVA Medical Center's financial statements, accounting records, indigent care and Medicaid cost reports, and other financial data provided as support for claimed UCC. We also selected a non-statistical sample of 400 cases to determine whether certain categories of claimed costs met the federal requirements to be included as part of the UVA Medical Center's UCC. We used a non-statistical sample because we could not project any results from a statistical sample. This non-statistical sample allowed us to disclose the attributes of the charges. Only through a recomputation of the cost report could we determine the effect of questionable charges. Therefore, we determined that a statistical sample selection would not be efficient or provide a reliable projection.

Our audit was performed in accordance with generally accepted government auditing standards. Our review of the UVA Medical Center's internal control structure was limited to obtaining an understanding of the process used to prepare the UVA Medical Center's UCC schedule. Our field work was performed at DMAS in Richmond, Virginia and the UVA Medical Center in Charlottesville, Virginia.

FINDINGS

The DMAS made $51,409,017 in DSH payments to the UVA Medical Center for SFY 1997 and $53,790,619 for SFY 1998. The DSH payments were calculated in accordance with the state plan. The UVA Medical Center claimed UCC of $58,876,753 and $56,203,046 for SFYs 1997 and 1998.

We found that UVA Medical Center overstated its UCC by including costs that were not consistent with the apparent purpose of section 1923 of the Act. We identified unallowable costs included in UCC totaling $10,302,524 for SFY 1997 and $8,814,198 for SFY 1998. As a result, DSH payments to UVA Medical Center exceeded its actual UCC for SFY 1997 by $2,834,788 ($1,459,632 FFP). For SFY 1998, DSH payments exceed UCC by $6,401,771 ($3,300,753 FFP) (see APPENDIX B). Overstated UCC resulted from the following:

- UVA Health Services Foundation costs of $10,302,524 for SFY 1997 and $8,814,198 for SFY 1998. Federal statute limits UCC to cost incurred by a hospital for furnishing hospital services. The amounts claimed, however, represented costs incurred by UVA Health Services Foundation (HSF) for treating indigent patients. Thus the costs were not UVA Medical Center incurred costs. The HSF and the UVA Medical Center were separate legal entities during SFYs 1997 and 1998.

We were unable to determine the reasonableness of UCC totaling $47,470,122 for SFY 1997 and $44,222,950 for SFY 1998 because the UVA Medical Center claimed costs for services provided in prior years.

- Indigent care costs of $47,470,122 for SFY 1997 and $44,222,950 for SFY 1998. Contrary to federal statute and the state plan, many patients that the UVA Medical Center classified as indigent had charges related to services provided in prior years.

OVERSTATED UNCOMPENSATED CARE COST

The UCC is defined as the sum of (1) the costs of services to Medicaid patients, less the amount paid by the state under the non-DSH payment provisions, plus (2) the costs of uninsured patients, less any cash payments made by them. The UVA Medical Center claimed UCC totaling $58,876,753 and $56,203,046 for SFYs 1997 and 1998, respectively. However, we found that the UVA Medical Center overstated its UCC by including costs that were not consistent with the apparent purpose of section 1923 of the Act. Unallowable costs included in UCC totaled $10,302,524 for SFY 1997 and $8,814,198 for SFY 1998.

Health Services Foundation Physician Costs

The UVA Medical Center included in its UCC, HSF costs of $10,302,524 for SFY 1997 and $8,814,198 for SFY 1998. During our audit period, HSF was a non-profit group practice organization comprised primarily of physician faculty employees of the UVA Health Sciences Center.

According to federal law, only costs incurred by a hospital may be included as part of its UCC. Specifically, section 1923 of the Act states:

> "(g) Limit on Amount of Payment to Hospital.---
> (1) Amount of Adjustment subject to uncompensated costs.---
> (A) In General---A payment adjustment during a fiscal year shall not be considered to be consistent with...respect to a hospital if the payment adjustment exceeds the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for

> medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year." (Underline added)

In an August 1994 State Medicaid Directors' Letter, CMS provided its interpretation of the OBRA of 1993 DSH provisions. In regard to cost of services under the DSH limit, the CMS stated that it would "...permit the State to use the definition of allowable costs in its State plan, or any other definition, as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement." The CMS believed this interpretation was reasonable because "...it provides States with a great deal of flexibility up to a maximum standard that is widely known and used in the determination of hospital costs."

The amounts included in UCC represented costs incurred by HSF physicians for treating indigent patients. The costs were not UVA Medical Center costs incurred for furnishing hospital services. The HSF and the UVA Medical Center were separate legal entities during SFYs 1997 and 1998. Further, the costs are unallowable under the Medicare cost principles. Therefore, the costs should not be included as part of the UVA Medical Center's UCC.

UNRESOLVED UNCOMPENSATED CARE COST

We were unable to render an opinion on UCC totaling $47,470,122 for SFY 1997 and $44,222,950 for SFY 1998. These costs represented the cost of treating uninsured indigent patients. Our review showed that, contrary to federal statute, a significant amount of the costs related to services provided in prior years.

Indigent Care Costs

The UVA Medical Center included in its UCC indigent care costs of $47,470,122 for SFY 1997 and $44,222,950 for SFY 1998. Indigent care costs represented the estimated costs of providing medical care to uninsured patients who qualify as indigent. A person is indigent if family income and assets do not exceed state limits. A cost sharing or copayment by an indigent patient may be required based on income level.

To determine uninsured indigent patient costs, the UVA Medical Center computed total indigent care costs through the indigent care cost report. First, total allowable and allocable costs were determined based on the UVA Medical Center's Medicare cost report. Next, indigent patients were apportioned their share of overall costs based on per diem cost amounts or based on percentages of costs compared to charges. Indigent charges represented write-off adjustments for unpaid charges for indigent patient services. The UVA Medical Center then deducted an estimate of cost sharing by indigent patients. Finally, the UVA Medical Center determined that approximately 90 percent of the net indigent costs represented uninsured patient costs and reported that amount on its UCC schedule.

Our review of indigent care costs found that, contrary to federal statute, a significant portion of indigent care charges related to services provided in prior years. Therefore, we are not expressing an opinion on indigent care costs claimed as part of UCC because we do not believe that the UVA Medical Center's methodology used to calculate the costs resulted in an accurate estimate of uninsured costs.

Indigent Care Charges Related to Services Provided in Prior Years

We found that approximately 20 percent of total indigent care charges had dates of service earlier than the year for which DSH payments were claimed. Some indigent charges were more than 5 years old. In SFY 1997, UVA Medical Center classified $54,398,213 in charges as indigent. Of those charges, $10,045,983 (18.5 percent) were for services with dates of service before SFY 1997, including $608,420 for charges for services provided before SFY 1992. In SFY 1998, indigent charges totaled $52,711,827. Of that amount, $11,647,514 (22.1 percent) had dates of service prior to SFY 1998, including $631,362 related to services provided prior to SFY 1993.

We believe that the UVA Medical Center's practice of including costs from prior periods in its UCC calculation is not in compliance with section 1923(g)(1)(A) of the Act that limits DSH payments to hospitals during a fiscal year to "...costs incurred during the year of furnishing hospital services...." The January 1995 letter to the State Medicaid Director's Association provided CMS's interpretation of this section of the Act. Specifically, CMS stated, "It is our belief that this language indicates that Congress intended States to match costs for hospital services provided during a particular year to payments received relating to those services provided for a particular year."

The following example illustrates UVA Medical Center's practice of including costs of prior periods into current UCC.

- On May 6 and May 20, 1992, a patient received a series of tests totaling $428. The patient was billed but did not pay. In May 1996, the patient qualified for Medicaid. In August 1996, UVA Medical Center classified the patient as indigent. The UVA Medical Center converted the charges to costs based on cost to charge ratios developed from its SFY 1997 cost report and included the costs in its UCC for SFY 1997.

Because we found that a significant portion of indigent care charges related to services provided in prior years, we are not expressing an opinion on indigent care costs claimed as part of UCC. The UVA Medical Center's UCC schedules should have included only those unreimbursed indigent care costs of uninsured patients for SFY 1997 and SFY 1998.

CONCLUSION AND RECOMMENDATIONS

Our review determined that for SFYs 1997 and 1998, the DSH payments made to UVA Medical Center were calculated in accordance with the state plan. However, we found

that UVA Medical Center overstated its UCC by including costs that were not consistent with the apparent purpose of section 1923 of the Act. We identified unallowable costs included in UCC totaling $10,302,524 for SFY 1997 and $8,814,198 for SFY 1998. Unallowable costs consisted of physician practice plan costs incurred by a related entity. As a result, DSH payments for SFYs 1997 and 1998 exceeded UCC by $2,834,788 ($1,459,632 FFP) and $6,401,771 ($3,300,753 FFP), respectively.

We also were unable to determine the reasonableness of UCC totaling $47,470,122 for SFY 1997 and $44,222,950 for SFY 1998 because the costs reported included costs for services provided in prior years. The UVA Medical Center's accounting system had the capability to remove unallowable costs from the UCC. We recommended that DMAS:

1. Refund $4,760,385 to the Federal Government for the federal share of DSH overpayments that resulted from unallowable physician practice plan costs included in UCC for SFYs 1997 and 1998.

2. Require UVA Medical Center to revise its methodology for computing UCC to exclude HSF physician practice plan costs and to include only the net costs to treat patients admitted without insurance in the year for which the DSH payment is made.

DMAS AND UVA MEDICAL CENTER COMMENTS AND OFFICE OF INSPECTOR GENERAL (OIG) RESPONSE

The DMAS disagreed with our findings and concurred with the UVA Medical Center's methodology for calculating UCC. The UVA Medical Center strongly disagreed with our findings and provided a lengthy response that can be found in APPENDIX C. The UVA Medical Center provided some general comments with respect to the lack of specific rules governing DSH payments and the OIG's authority to conduct the review. The response also focused on the questioned physician practice plan costs, and the methodology for computing indigent care costs.

General Comments

UVA Medical Center Comments

The UVA Medical Center noted that CMS never issued regulations interpreting the hospital specific limits of the DSH statute. The UVA Medical Center stated that absent the creation of more specific rules through a proper rulemaking, it was not appropriate (for OIG) to audit to specific standards that narrow the breadth of payments that are permissible under the statute. It concluded that our audit was an attempt to interpret the Act, which OIG is specifically barred from doing under the Inspector General Act (5 U.S.C section 8G(b)).

The UVA Medical Center also stated that our audit should have ended once we concluded that the DSH payments were calculated in accordance with the state plan since the state plan was approved by CMS.

OIG Response

We conducted our audit under the authority granted by the Inspector General Act of 1978, as amended, which provided for an independent OIG within the Department of Health and Human Services to conduct and supervise audits and investigations relating to department programs and operations. We acknowledge that there have been no CMS regulations issued interpreting the hospital specific DSH limits under section 1923(g) of the Act. Therefore, the criteria we used in conducting our audit were the DSH statute, CMS interpretation of the DSH statute in the form of guidance letters issued to State Medicaid Directors, and Medicare cost principles used in determining hospital costs. Our review was conducted at the request of CMS as part of a multi-state initiative. At the conclusion of those reviews, OIG will make additional recommendations aimed at improving the DSH program directly to CMS.

Our statement that the DSH payments were made in accordance with the state plan merely reflected the fact that DMAS compared its payments to the UCC claimed by UVA Medical Center. We did not intend to imply that the UCC was consistent with the apparent purpose of section 1923(g). That was the second objective of our audit.

HSF Physician Costs

UVA Medical Center Comments

The UVA Medical Center responded that there is no definition of hospital services for purposes of DSH in statute or regulation. In addition, the CMS approved state plan refers to hospitals receiving DSH payments for costs incurred for services in serving persons who have no insurance. The UVA Medical Center stated that it had specifically inquired of DMAS as to whether the costs incurred by HSF in furnishing services on UVA Medical Center's premises could be included in the UCC formula, and DMAS responded that they could be included.

The UVA Medical Center also pointed out that the August 1994 State Medicaid Directors' Letter gives states significant flexibility in determining cost of services as long as the costs do not exceed the amount that would be allowable under Medicare principles of cost reimbursement. The UVA Medical Center argued that under a wide array of circumstances, providers are allowed to include the costs of physician services on their cost reports. Teaching hospitals are allowed to elect to receive reimbursement for the reasonable costs of physician services provided at their facilities. Medicare cost principles also allow hospitals to include on their cost reports reasonable costs for services furnished by related organizations and HSF meets the Medicare definition of a related organization. Finally, the UVA Medical Center stated that OIG, on its own

initiative, added the costs of physician services incurred by Kern Medical Center[1] to that hospital's allowable operating expenses and asked for similar treatment based on fairness and consistency.

OIG Response

We disagree with UVA Medical Center's position regarding the inclusion in UCC of HSF costs. We believe that the explicit language of the DSH statute, CMS interpretation of the statute, and Medicare cost principles support our position that HSF physician costs should not be included as part of UVA Medical Center's UCC.

Section 1923 (g)(1)(A) of the Act states that a DSH payment shall not exceed, "...the costs incurred during the year of furnishing hospital services...by the hospital...." By this language we believe that the Congress intended DSH payments to compensate a hospital for costs it incurred for furnishing hospital services.

In August 1994, CMS provided its interpretation of the DSH statute to State Medicaid Directors. The CMS allowed states flexibility in defining allowable cost of hospital services subject to the DSH limit, "...as long as the costs determined under such a definition do not exceed the amounts that would be allowable under Medicare principles of cost reimbursement." The CMS believed its interpretation was reasonable because its maximum standard (Medicare cost principles) was, "...widely known and used in the determination of hospital costs."

The UVA Medical Center used its Medicare cost report as the basis of its indigent care cost report. The HSF physician costs, however, were not included in UVA Medical Center's Medicare cost report but instead were compiled separately from costs supplied by HSF and included as an additional cost in UVA Medical Center's UCC report. The costs were not included in UVA Medical Center's Medicare cost report for good reason--the costs do not meet Medicare cost principles for determining hospital costs. In fact, physician costs must meet specific requirements to be included in a hospital's Medicare cost report.

Hospitals are reimbursed for costs incurred in the compensation of provider-based physicians (42 CFR 415.60). However, reimbursement is only made for the portion of physician time spent on non-patient-related services to the hospital (provider component). Physician time spent on patient related services (professional component) is not allowable. The professional services rendered by a physician are not reimbursable

[1] *Audit of California's Medicaid Inpatient Disproportionate Share Hospital Payment for Kern Medical Center, Bakersfield, California, State Fiscal Year 1998* (HHS/OIG Report Number A-09-01-00098, September 17, 2002).

through the cost report because the Medicare Part B carrier reimburses them based on the applicable fee schedule amount (42 CFR 414.21).[2]

There are additional rules applicable to physician services in teaching settings that would apply to UVA Medical Center as a teaching hospital. Specifically, a teaching hospital ***may elect*** to receive payment on a reasonable cost basis for the direct medical and surgical services of its physicians in lieu of fee schedule payments that might otherwise be made for these services (42 CFR 415.160). Physician services would include those provided by HSF physicians. The UVA Medical Center, however, did not make this election. Therefore, physician services provided by HSF physicians to Medicare beneficiaries were reimbursed to HSF on a fee schedule basis. Consequently, HSF physician costs for providing these services were not includable on UVA Medical Center's cost report.

The circumstances with respect to the physician services at Kern Medical Center differed significantly from those surrounding the HSF physician services claimed by UVA Medical Center. In the case of Kern Medical Center, a county-owned hospital, provider-based physicians employed by the hospital provided the services. Under California law, Kern Medical Center was permitted to employ physicians, making costs associated with professional medical services provided by those physicians a recognizable hospital cost. Unlike UVA Medical Center, Kern Medical Center included the professional component of the costs in the non-reimbursable category of its Medicare cost report. Accordingly, OIG recognized the costs associated with the professional medical services provided by those physicians to be hospital-incurred costs and included the costs in the calculation of the UCC limit.

Indigent Care Costs

UVA Medical Center Comments

The UVA Medical Center acknowledged that its UCC included indigent care cost from prior years' services. This occurred because there were services furnished around the end of the year when it was virtually impossible to determine the indigence of the patient prior to yearend and sometimes there were long delays in obtaining from patients the information needed to verify indigence. While the indigence determination was pending, the patient's cost was not included in UCC. The UVA Medical Center also stated that OIG did not consider the substantial indigent care costs reported subsequent to the audited years for services furnished in 1997 and 1998.

[2] An exception to the basic rule that Medicare makes payment to the provider who provides the service occurs where payment is made to an employer. Specifically, Medicare may pay a physician's employer if the physician is required, as a condition of employment, to turn over to the employer the fees for his or her services (42 CFR 424.80(b)).

OIG Response

We believe that DSH statute and CMS's interpretation of the statute limits DSH payments to hospitals for a fiscal year to costs incurred during the year of furnishing hospital services to Medicaid patients or patients with no insurance. We also agree with UVA Medical Center that this is essentially a timing issue. However, not all indigent patients qualify to have their medical costs reimbursed through DSH payments. This is because indigent status only refers to the patient's level of income and assets and not whether or not the patient has health insurance coverage. We see no reason for UVA Medical Center to delay claiming as part of UCC the cost of treating patients without insurance.

APPENDIX A

Summary Schedule
Audit Adjustments to Uncompensated Care Costs

State Fiscal Year 1997

Cost Element	Claimed UCC	OIG Adjustments	Adjusted UCC	Unresolved UCC
Non-HMO Patients	$(6,249,608)		($6,249,608)	
Hospital Costs > 21 Days	$1,021,144		$1,021,144	
Emergency Room	$588,149		$588,149	
Clinic	$254,321		$254,321	
Outpatient Laboratory	$189,681		$189,681	
Pediatric Transplant	$73,479		$73,479	
Medicaid Patient Costs	($4,122,834)	$0	($4,122,834)	$0
Indigent Care	$47,470,122		$47,470,122	$47,470,122
Physician Practice Plan	$10,302,524	$10,302,524		
Bad Debt Write-Off	$4,555,571		$4,555,571	
State Only	$1,998,256		$1,998,256	
Self-pay	($1,326,886)		($1,326,886)	
Uninsured Patient Costs	$62,999,587		$52,697,063	$47,470,122
TOTAL UCC	**$58,876,753**	**$10,302,524**	**$48,574,229**	**$47,470,122**

State Fiscal Year 1998

Cost Element	Claimed UCC	OIG Adjustments	Adjusted UCC	Unresolved UCC
Non-HMO Patients	($10,743,214)		($10,743,214)	
Hospital Costs > 21 Days	$3,372,978		$3,372,978	
Emergency Room	$560,966		$560,966	
Clinic	$214,263		$214,263	
Outpatient Laboratory	$195,007		$195,007	
Pediatric Transplant	($107,567)		($107,567)	
Medicaid Patient Costs	($6,507,567)	$0	($6,507,567)	$0
Indigent Care	$44,222,950		$44,222,950	$44,222,950
Physician Practice Plan	$8,814,198	$8,814,198		
Bad Debt Write-Off	$9,337,884		$9,337,884	
State Only	$1,679,053		$1,679,053	
Self-pay	($1,343,472)		($1,343,472)	
Uninsured Patient Costs	$62,710,613	$8,814,198	$53,896,415	$44,222,950
TOTAL UCC	**$56,203,046**	**$8,814,198**	**$47,388,848**	**$44,222,950**

APPENDIX B

Summary Schedule
Computation of Excess Disproportionate Share
Hospital Payment

	1997		1998	
	Total Computable	**Federal Share**	**Total Computable**	**Federal Share**
DSH Payments	$51,409,017	$26,472,189	$53,790,619	$27,733,148
Less: Adjusted UCC	$48,574,229	$25,007,408	$47,388,848	$24,432,395
Excess DSH Payments	**$2,834,788**	**$1,459,632**	**$6,401,771**	**$3,300,753**

Average Federal Share: SFY 1997 = 51.49%; SFY 1998 = 51.56%

APPENDIX C

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES AND UNIVERSITY OF VIRGINIA MEDICAL CENTER COMMENTS

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

PATRICK W. FINNERTY
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)

November 19, 2002

Mr. Stephen Virbitsky
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of the Inspector General
Office of Audit Services
150 S. Independence Mall West, Suite 316
Philadelphia, Pennsylvania 19106-3499

Dear Mr. Virbitsky:

This letter is a follow up to my letter of November 13, 2001 regarding the OIG draft reports which I shall refer to collectively as "Review of Medicaid Disproportionate Share Hospital Payments made by Virginia's Department of Medical Assistance Services to the Medical College of Virginia Hospitals (MCVH) and the University of Virginia Medical Center (UVA Medical Center) for Fiscal Years Ending June 30, 1997 and June 30, 1998".

We agree with the findings and conclusions of the responses submitted by both MCVH and the UVA Medical Center, and we request that the OIG revise its proposed adjustments to be consistent with these responses and their respective conclusions. As acknowledged in the draft reports, disproportionate share hospital (DSH) payments made by Virginia's Department of Medical Assistance Services were in accordance with our Medicaid State Plan which has been appropriately reviewed and approved by the federal Centers for Medicare and Medicaid Services. We not only have confidence that Virginia's existing methods for determining uncompensated care costs and calculating DSH payments are consistent with our State Plan and related federal requirements, we also believe that the calculations included in the responses by MCVH and the UVA Medical Center confirm the validity of these methods.

In light of the differences between the draft reports and the responses, it is our recommendation that a meeting be scheduled with this office to review the responses prior to your completion of final reports. By this letter, I request that you accept this recommendation and that we schedule a meeting at our mutual convenience.

Thank you for consideration of our responses as well as our request for a meeting. If you have any questions, please contact me at (804) 786-8099 or Stanley Fields at (804) 786-5590.

Sincerely,

Patrick W. Finnerty
Director

Cc: Manju Ganeriwala
Stanley Fields
Dom Puleo, MCV Hospitals/VCUHS
Larry Fitzgerald, UVA Medical Center

UNIVERSITY of VIRGINIA HEALTH SYSTEM

Office *of the*
Senior Associate Vice President *for* Finance

November 13, 2002

Mr. Steven Virbitsky
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Inspector General
Office of Audit Services
150 S. Independence Mall West, Suite 316
Philadelphia, Pennsylvania 19106-3499

Re: Common Identification Number A-03-01-0226 (Review of Medicaid Disproportionate Share Hospital Payments Made by Virginia's Department of Medical Assistance Services to the University of Virginia Medical Center for the Fiscal Years Ending June 30, 1997 and June 30, 1998)

Dear Mr. Virbitsky:

In connection with the audit by the Department of Health and Human Services Office of Inspector General ("OIG") of uncompensated care costs ("UCC") by the University of Virginia Medical Center ("UVA Medical Center") for State Fiscal Years 1997 and 1998, this letter responds to the principal findings contained within the draft report, dated August, 2002 (the "Draft Audit Report").

There are three general findings in the Draft Audit Report:

- UVA Medical Center did not offset a gain of $6 million on certain Medicaid services in 1997;
- UVA Medical Center is not entitled to include in the UCC calculation costs incurred by the faculty practice plan furnishing services on UVA's premises to admitted inpatients or hospital registered outpatients; and
- UVA Medical Center did not properly compute costs for indigent care and bad debts, although the Draft Audit Report did not propose any specific adjustments with respect to these issues.

We disagree with all of these findings for the reasons summarized in this letter.

Based on these findings, OIG has made several recommendations to Virginia's Department of Medical Assistance Services ("DMAS"). With respect to the alleged overstatements relating to Medicaid net gains and the inclusion in the UCC of related entity

costs, it suggests that DMAS require UVA Medical Center to reduce its UCC by the corresponding amounts in the applicable State fiscal years. OIG also recommends that DMAS require UVA Medical Center to recalculate its UCC in a manner that includes only the actual costs of uninsured patients, net of payments received on their behalf. Further, according to the OIG, DMAS should return to the Federal government the Federal share of any overpayments resulting from these actions. Lastly, the OIG believes that DMAS should implement controls to ensure "accurate" preparation of the UCC schedules in the future.

The DSH payments at issue are authorized by 1993 amendments to the Federal Medicaid statute Section 1923(g) of the Social Security Act. This statutory provision limits the amount of disproportionate share hospital ("DSH") payments that a provider can receive. According to the statute, DSH payments are limited to:

> the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this subchapter, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year.

42 U.S.C. § 1396r-4(g)(1)(A).

The statute has never been interpreted by the Secretary in a regulation. Absent the creation of more specific rules through a proper rulemaking pursuant under the Administrative Procedure Act, it is not appropriate to audit to specific standards that narrow the breadth of payments that are permissible under the statute. The CMS letters suggesting its policy in interpreting the statute are interesting but do not have the force and effect of law since they have not been promulgated as regulations, which is the only way that the Secretary can properly create substantive standards. Moreover, OIG is expressly barred by statute from entering into the realm of making policy or undertaking program responsibilities. 5 U.S.C. §8G(b). Thus, OIG's recitation of certain conclusions about the proper interpretation of the statute is improper; the role of interpreting the statute falls solely to the Secretary and the Secretary can properly create standards only through rulemaking.

It is important that OIG determined that UVA Medical Center's DSH payments were calculated in accordance with the approved State plan. We agree. That State plan has been approved by CMS and once OIG concludes that payments have been made "in accordance with the State plan," the audit should be closed with no proposed adjustments. To the extent that OIG concludes that the State plan is not consistent with federal law, then OIG should criticize CMS, but the only appropriate remedy if such findings were correct would be the prospective amendment of the State plan. Indeed, retrospective amendment of State plans is barred by CMS's regulations. 42 C.F.R. § 430.20(a). Therefore, without violating CMS regulations, DMAS could not implement the OIG's recommendation to require UVA Medical Center to

reduce its stated UCC for the two State fiscal years in question and return the Federal share of any resulting repayment to the Federal government.

I. Distinction Between DSH Payments and the UCC

At the outset, it is important to distinguish between the amounts paid to UVA Medical Center in DSH and the UCC. The amount of DSH payments claimed for UVA Medical Center for 1997 and 1998 were less than the UCC amounts calculated for UVA.

Year	DSH Payment	Calculated UCC	Excess of UCC over DSH Payment
1997	$51,409,017	$58,876,753	$7,467,736
1998	$53,790,619	$56,337,714	$2,547,095

Thus, as settled by DMAS, the DSH payments to UVA Medical Center were less than the UCC by substantial amounts.

This portion of UVA Medical Center's response has been deleted as it pertained to matters included in the draft report which are no longer contained in the final report.

This portion of UVA Medical Center's response has been deleted as it pertained to matters included in the draft report which are no longer contained in the final report.

III. Inclusion of Physician Costs in the UCC

3.1 Relevant Facts

The Draft Audit Report correctly reports that UVA Medical Center included Health Services Foundation ("HSF") costs of $10,302,524 for SFY 1997 and $8,814,198 for SFY 1998 in the UCC calculation. HSF is a "related organization" treating UVA Medical Center indigent patients on UVA's premises. The Draft Audit Report characterizes these amounts as "estimated costs incurred by UVA Health Science [sic, Services] Foundation physicians for treating indigent patients." This is a misleading statement. HSF's costs relating to treating UVA Medical Center's patients were computed using the same methodology used to compute other UCC amounts and used accepted cost finding and apportionment principles. The amounts were computed using the ratio of indigent charges to total charges applied to costs adjusted to eliminate "nonallowable" costs. This same methodology is used universally, and did not evoke any other comments in the draft report that it resulted in estimates. The Draft Audit Report proposes to adjust those costs because they were not UVA Medical Center's costs.

The indigent patients treated by HSF were easily identifiable. UVA Medical Center and HSF shared the same registration system so that patients were simultaneously registered as UVA Medical Center and HSF patients. UVA Medical Center and HSF also used the same determinations of indigence. Thus, a patient determined to be indigent by UVA Medical Center was also reflected as indigent in HSF's billing system, and only those patients who were indigent in UVA Medical Center's billing system were classified as indigent in HSF's billing system.

The costs for services furnished by HSF to UVA Medical Center patients was determined by computing the percentage of HSF's charges for indigent patients to its total charges. That amount was applied to HSF's costs (which for purposes of this calculation were substantially less than the full amount of HSF's costs on its financial statement that was requested and furnished to the OIG auditor). UVA Medical Center has furnished the worksheet showing the calculation of HSF's costs and is not aware of any objections relating to the manner in which those costs have been computed.

UVA Medical Center specifically inquired of DMAS as to whether the costs incurred by HSF in furnishing services on UVA Medical Center's premises could be included in the UCC formula, and DMAS responded affirmatively that they could be included. This is reflected in an e-mail from DMAS to UVA, Exhibit 2, and handwritten additions made by DMAS personnel to UVA Medical Center's supplemental cost report information supporting Worksheet H-1, Pt. II, line 9 of UVA Medical Center's Medicaid cost report, Exhibit 3 for 1997 and Exhibit 4 for 1998. DMAS based this instruction on its reasoned interpretation of its State plan and applicable Federal authorities. Significantly, the Draft Audit Report does not claim either that: (a) the language of the State plan is non-compliant with Federal law; or (b) DMAS' interpretation of its State plan is in error. It is therefore unclear why UVA Medical Center's UCC calculations are now deemed incorrect.

3.2 Applicable Law

Applicable law supports the proposition that costs relating to physician services incurred by a hospital in treating Medicaid and uninsured patients are includible in the UCC limit. This conclusion remains true, notwithstanding the inconsistent interpretation of the statute accorded by regulatory authorities.

3.2.1 Statutory Language

The UCC statute limits DSH payments to:

> the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this subchapter, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year.

42 U.S.C. § 1396r-4(g)(1)(A). The term "hospital services" is not defined in 42 U.S.C. § 1396r-4 or anywhere else in Title XIX of the statute. Further, other than in the provision regarding UCC limits, Section 1396r-4 does not use the term "hospital services". Under the rules of statutory interpretation, when a different term is used, that means that a different meaning is intended. Congress did not use the term "inpatient hospital services," which appears consistently throughout the other provisions of Section 1396r-4, or any other statutory terms of art; it used a new term and that necessarily means that Congress intended the term to be interpreted differently from the existing statutory terms.

3.2.2 CMS Interpretation

As with all requirements applicable to Medicaid, CMS is charged with the interpretation of the UCC limit provision. This means that, to the extent that certain aspects of the statute are not clear, they can be interpreted by the Secretary. However, such interpretation can occur only through rulemaking subject to notice and public comment and pursuant to the Administrative Procedure Act. We do not believe that the Secretary could properly interpret the statute to exclude physician costs from the calculation of the UCC limits. But that is not the issue in this instance; rather, the issue here is whether this restrictive interpretation of the statute can be applied to justify retrospective recoveries when there has been no properly promulgated rule. Indeed, based on the Secretary's approval of this State plan as well as other State plans that clearly include the cost of physician services in the calculation of the UCC, it does not appear that the Secretary has reached an interpretation that physician services may not be included in the UCC calculation, even informally and in a manner not consistent with proper rulemaking procedures. There can be no issue that OIG can substitute its interpretation for that of the Secretary. As noted above, the statute governing OIG operations clearly bars OIG from interpreting the law or in any way making program decisions.

Notwithstanding its authority to issue regulations, the agency has never promulgated any regulations, even in proposed form, and has provided no notice of any interpretation or sought public comments. Further, the key terms in the statute, such as "hospital services", are not otherwise defined in the Medicaid regulations. Although there are definitions of "inpatient hospital services" (42 C.F.R. § 440.10) and "outpatient hospital services" (42 C.F.R. § 440.20), nowhere is there a definition of "hospital services". It is reasonable to conclude that CMS has chosen instead to allow the States to use their discretion in interpreting what constitutes "hospital services" in any reasonable fashion, in accordance with the flexibility reserved for the States in designing and implementing their State plans.

While CMS has yet to promulgate or implement any formal rules relating to UCC, it has offered some informal guidance on a few of the significant issues arising from the UCC's implementation. According to the summary of the statute circulated to State Medicaid directors that is quoted in the Draft Audit Report:

> First, the legislative history of this provision makes it clear that States may include both inpatient and outpatient costs in the calculation of the limit. Second, in defining "costs of services" under this provision, HCFA would permit the State

> to use the definition of allowable costs in its State plan, or any other definition, as long as the costs determined under such a definition do not exceed the amounts that would be allowable under Medicare principles of cost reimbursement. The Medicare principles are the general upper payment limit under institutional payment under the Medicaid program. HCFA believes this interpretation of the term "costs incurred" is reasonable because it provides States with a great deal of flexibility up to a maximum standard that is widely known and used in the determination of hospital costs."

State Medicaid Directors' Letter, dated August 17, 1994, p. 3. Hence, according to this guidance, "hospital services" can include both inpatient and outpatient costs. Tracking the wording of the legislative history, CMS does not use the terms "inpatient hospital services" or "outpatient hospital services", which are defined in Medicaid regulations, and thus it appears that neither Congress nor CMS intended to circumscribe the range of services to simply those that were already codified in regulation. Further, in this guidance, there is no prohibition against including costs other than inpatient costs and outpatient costs. Rather, this guidance appears to create a "floor" regarding the scope of services to be included instead of a "ceiling". Based on these limited statements, it is impossible to determine what CMS would have established as the boundaries on includible costs had it chosen to engage in notice and comment rulemaking.[2] Without any such rule, there is no basis for rejecting any reasonable interpretation a State may put forward.

Had CMS chosen to promulgate a regulation defining "hospital services" as both "inpatient hospital services" and "outpatient hospital services" in accordance with existing Medicaid regulations, physician services furnished to a provider's patients would have been implicitly covered. As defined in Medicaid regulations, "inpatient hospital services" must, among other criteria, be "furnished under the direction of a physician or dentist." 42 C.F.R. § 440.10. The physician's involvement is thus inextricable. Similarly, "outpatient hospital services" must, among other criteria, be "furnished by or under the direction of a physician or dentist." 42 C.F.R. § 440.20 (emphasis added). Thus, with respect to the outpatient hospital services, there is *no* ambiguity that physician services are an integral component of hospital services.

Within the context of payment for indigent care to hospitals qualifying for DSH payments, it is especially clear that physician services are an indispensable component of hospital services. In enacting the DSH statute, Congress sought to protect access for Medicaid and uninsured patients to healthcare services by providing compensation to the hospitals that disproportionately handle the needs of this vulnerable population. However, hospitals cannot furnish services without the collaborative efforts of the physicians at their facilities, who must examine the patients, develop a diagnosis, and implement a plan of care. Thus, to fail to include the costs of physician services incurred by the hospitals in treating the same group of indigent patients jeopardizes the ability of these hospitals to fulfill their congressional mandate. To

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[2] Even if determinable, for CMS' guidance to be binding, it must be properly promulgated as a rule subject to the Administrative Procedure Act.

interpret the DSH statute in a manner that frustrates its purpose would exceed CMS' authority if it were to promulgate regulations prohibiting the inclusion of physician costs in the UCC. Needless to say, such an interpretation is even more problematic when initially put forth by OIG.

CMS' 1994 letter also sets forth its non-binding view of how the statutory phrase "costs incurred . . . by the hospital" should be interpreted. The letter allows institutions to include in their UCC limits all costs that can be included on the cost report as reimbursable costs. As the rationale for this position, the letter posits that this approach strikes a balance between flexibility and predictability. Use of the cost report, it could be argued, provides tremendous breadth because there is a wide range in costs that can be included on the cost report to account for the large variability among providers.

Using CMS' informal and non-binding policy statement as a guide, uncompensated costs of physician services furnished to hospital patients on hospital premises would qualify as costs incurred by the hospital. Under a wide array of circumstances, providers are allowed to include the costs of physician services on their cost reports. For instance, teaching hospitals are allowed to elect to receive reimbursement for the reasonable costs of physician services provided at their facilities. 42 C.F.R. § 415.160. Such costs appear on Worksheet D-9, Part II of a facility's Form 2552-96 cost report. Provider Reimbursement Manual II, § 3626.2. When the services are rendered through a related entity, the provider is entitled to the entire amount of reasonable costs incurred by the related entity relating to the services furnished at the provider. 42 C.F.R. § 415.162(c). Similarly, critical access hospitals ("CAHs") can receive payments for the compensation and related costs of emergency room physicians who are on call but not present on the premises of the CAH. 42 C.F.R. § 413.70(b)(4)(i). The OIG itself has recently recognized that physician costs properly appear on a provider's cost report. Accordingly, on its own initiative, it added the costs of physician services incurred by Kern Hospital Medical Center to the hospital's allowable operating expenses. In light of this recent report, principles of consistency and fairness require that the OIG allow inclusion of UVA Medical Center's costs of physician services in its UCC limit as well. To act otherwise would underscore the arbitrary and capricious manner in which the limited CMS guidance is applied in the absence of clear rules that were developed through notice and comment rulemaking.

3.2.3 State Plan

The Commonwealth of Virginia has enacted sections of the State plan that set forth its DSH calculation methodology, including provisions relating to the UCC limits, in a manner which accords with all applicable Federal requirements. The provisions relating to the UCC calculations that are presently in effect are as follows:

A payment adjustment during a fiscal year shall not exceed the sum of:

1. Medicaid allowable costs incurred during the year less Medicaid payments, net of disproportionate share payment adjustments, for services provided during this year. Costs and payments for Medicaid recipients enrolled in

> capitated managed care programs shall be considered Medicaid costs and payments for the purposes of this section.
>
> 2. Costs incurred in serving persons who have no insurance less payments received from those patients or from a third party on behalf of those patients. Payments made by any unit of the Commonwealth or local government to a hospital for services provided to indigent patients shall not be considered to be a source of third party payment.

State Plan, Attachment 4.19A, page 13 of 26, effective date July 1, 1998. The provisions in effect prior to the present provisions applied to SFY 1997, stating:

> A payment adjustment during a fiscal year shall not exceed the sum of "Medicaid losses" and "uninsured losses".
>
> "Medicaid losses" mean Medicaid allowable costs incurred during the year less Medicaid payments, net of disproportionate share payment adjustments, for services provided during the year.
>
> "Uninsured losses" means costs incurred in serving persons who have no insurance less payments received from those patients or from a third party on behalf of those patients. Payments made by any unit of the Commonwealth or local government to a hospital for services provided to indigent patients shall not be considered to be a source of third party payment.

State Plan, approval date October 30, 1996. Both the new and superseded provisions only use the term "services" rather than "hospital services" in defining the scope of the services for which costs can be included in the UCC limit. The Commonwealth has used the general term "services" to emphasize its intention to include costs relating the full range of services that may be construed as "hospital services". In its comprehensiveness, this provision clearly covers physician services.

DMAS has acted in accordance with the approved State plan and has consistently accepted and expected the inclusion of the uncompensated care costs relating to physician services in UVA Medical Center's UCC calculations. DMAS has expressly stated this policy in correspondence sent to UVA Medical Center, and it has verified that these costs were properly included during its audit of the institution's UCC schedules. In taking these actions, DMAS has permissibly interpreted its State plan, which properly tracks Federal requirements.

CMS has affirmatively approved of DMAS' actions through its approval of the expansive language of the State plan. The Commonwealth submitted each of the State plan amendments containing the UCC provisions to the CMS Regional Office for Region III seeking its authorization. Upon submission, the regional staff had the opportunity to consider the provisions of these amendments, discuss any issues with DMAS, and consult with CMS central office staff regarding any policy issues. 42 CFR § 430.14. The approval of DMAS' State plan amendments

signified that CMS has found that the proposed provisions comply with all applicable Federal laws and regulations. 42 C.F.R. § 430.15. In other words, CMS, through its active review process, has ensured that DMAS has not enacted UCC provisions in contravention of Medicare statutory and regulatory provisions. Implicit in its authorization of Virginia's State plan provisions, therefore, is CMS' interpretation of the scope of the term "hospital services", as used in the UCC statute, as comprising any and all "services". In accordance with this authorization, the term clearly includes physician services.

CMS' determination with respect to the UCC provisions contained in Virginia's State plan is not unusual. CMS has expressly allowed for inclusion of physician services in the UCC provisions of several other States. For instance, the South Carolina State plan clearly allows the inclusion of the uncompensated costs relating to emergency room physicians under certain circumstances. South Carolina State Plan, Attachment 4.19-A, p. 29. Similarly, Massachusetts expressly includes the uncompensated costs of physician services in its calculations of the UCC limit. Massachusetts State Plan, Attachment 4.19-A, p. TN 00-14 (incorporating certain regulations attached as exhibits to the State plan). Clearly, to the extent there is any CMS "policy" rejecting the inclusion of uncompensated costs of physician services in the UCC limit, it is not one of national application.

Even if CMS were now to disagree with DMAS regarding the proper interpretation of its approved State plan provisions, the Commonwealth is entitled to deference. As often stated by the CMS Departmental Appeals Board, deference is warranted "to a state's interpretation of ambiguous language in its own plan, provided the interpretation is reasonable and does not conflict with federal requirements." Louisiana Dept. of Health and Hospitals, DAB Dec. No. 1542 (1995); *see also* Virginia Dept. of Medical Assistance Services v. CMS, DAB Dec. No. 1838 (Aug. 2, 2002) (upholding DMAS' entitlement to deference in its interpretation of its DSH payment system). Given the breadth of the term "services" and the lack of any contrary Federal requirements that could be construed as binding on the Commonwealth, it is entitled to deference in its interpretation of its UCC provision. The modern trend has been towards even greater deference to the States with respect to their State plans. Accordingly, Congress repealed the Boren Amendment to alleviate Federal regulation of State Medicaid functions, and CMS has acknowledged that this congressional act was aimed at decreasing CMS' role in overseeing State payment systems. 64 Fed. Reg. 54263, 54264 (Oct. 6, 1999). Imposing at this point a previously unarticulated policy that has never been subject to proper rulemaking would clearly conflict with the authority envisioned for State agencies such as DMAS by Congress and the pertinent administrative bodies.

3.2.4 Status of UVA Medical Center and HSF

If Medicare principles of reimbursement are to be used in determining the amount costs incurred by UVA Medical Center, in accordance with the principles set out in CMS' 1994 letter, HSF's costs are properly includible. Under the related organization principle, a provider should report costs incurred by a related organization without regard to the provider's payments to the related organization. 42 C.F.R. § 413.17. This is not a one-sided principle where it is the lesser of the costs incurred by the related organization or the amount paid by the provider; rather, the

rule simply states that the related organization's costs shall be treated as the provider's costs. Thus, HSF's costs were properly included by UVA Medical Center in the UCC calculation without regard to whether UVA Medical Center transferred funds to HSF for those services.

HSF is an organization that is related to UVA Medical Center under the Medicare related organization principle. It has been treated as related to UVA Medical Center in every Medicare cost report since 1980 when HSF was formed. HSF physicians are the only physicians (other than residents) who furnish services on UVA Medical Center premises with only a handful of exceptions. HSF physicians are the chairs of every clinical department at UVA. HSF physicians practice almost exclusively at UVA. UVA appoints members to HSF's Board. In the event of HSF's dissolution, its assets flow to UVA. The parties share patient registration. The medical records are jointly owned by UVA Medical Center and HSF. In short, the two organizations are inextricably entwined and it is inconceivable that anyone could reasonably determine that there is not significant common control as defined by the Medicare related organization principle. [3] UVA Medical Center is not unique as an academic medical center since the affiliated physician groups that are the medical staff of a teaching hospital typically are treated as related to the hospital. (Indeed, we are not aware of any exceptions to this treatment.) In any event, the relatedness of UVA Medical Center and HSF is not based on speculation of how they might be treated under the applicable principles of reimbursement. The fact is Medicare has treated UVA Medical Center and HSF as related since HSF was first formed in 1980.

The Draft Audit Report makes an issue of HSF being a separate legal organization. Under the related organization principle, that makes no difference as is clearly stated on the face of the regulation:

> If a provider obtains items or services, facilities, or supplies from an organization *even though it is a separate legal entity*, and the organization is owned or controlled by the owners(s) of the provider, in effect the items are obtained from itself.

42 C.F.R. § 413.17(c)(2) (emphasis added).

Funds have transferred between UVA and HSF for many purposes, including payments to HSF by UVA Medical Center for services furnished to indigents. However, the existence and amount of such transfers is legally irrelevant. Under the clear language of the related organization principle, a provider can claim the cost of a related organization; there is no provision that the provider is entitled to the lesser of the related organization's costs or the amount it pays the related organization:

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[3] Control under the Medicare related organization is far less than legal control, Provider Reimbursement Manual § 1002.1, and the definition of related parties in 42 C.F.R. § 413.17(b)(1) refers to parties being related when they are "affiliated with" each other. For years, there has been an affiliation agreement between UVA Medical Center and HSF.

> If the provider obtains items or services ... from a [related] organization ... in effect the items are obtained from itself. ... Therefore, *reimbursable cost should include the costs for these items at the cost to the supplying organization.*

42 C.F.R. § 413.17(c)(2). In the context of academic medical centers, the related organization principle is routinely applied to permit the provider to be reimbursed for costs incurred by an affiliated physician group in excess of the amount, if any, transferred by the provider to the physicians. This application of the related organization principle is not unique to academic medical centers but is routinely applied in other situations as well. One reported case deals with this issue. A nonprofit community hospital was able to lease city-owned facilities for far less than the city's costs. When the hospital convinced the Provider Reimbursement Review Board that the hospital and city were related, the city's full costs of ownership were allowed as provider costs even though those costs far exceeded the rent actually paid by the hospital. PRRB Dec. No. 76-D76.

In summation, the fact that the physician costs included in the UCC calculation were incurred by a separate legal entity is irrelevant under long-established principles of payment, and CMS has been clear that those principles of payment determine what costs can be allowed for services that can be included in the UCC.

IV. Indigent Care Costs

4.1 What Was Audited and What Was Not Audited

As described in the Draft Audit Report, a nonstatistical sample of 100 indigent care charges was taken for each year, 1997 and 1998. The audit did not examine at all the systems established by UVA Medical Center to verify indigence. Through the entire time period audited, UVA Medical Center had in place good procedures to verify patient's indigence. There were five levels of indigence. At the highest level, all payments were waived, and for the remaining four levels, there was a sliding scale of amounts waived. (More than half of the indigent patients qualified for the full waiver of charges.) The indigence standards were based on the federal poverty guidelines. Those standards were revised annually, and were approved by the Commonwealth. For a patient to qualify for indigent status, the patient had to furnish verifiable information on both income and assets. Indeed, in many instances, the indigency determination would be delayed for a considerable time period because the patient did not furnish the requested information. Until the patient furnished the information showing that he or she met the qualifications to be treated as an indigent, UVA Medical Center billed the patient and pursued, to the extent reasonable, collection. UVA Medical Center did so to give the patient an incentive to furnish the documentation to support an indigency determination. On a number of occasions, however, the patient did not have adequate incentive to furnish the documentation of income and assets until the patient again needed hospital services.

Annually, UVA Medical Center files with the Commonwealth an indigent care cost report which includes a detailed listing of patients qualifying for indigent status. The indigent care cost report is the raw data used to calculate the UCC but, as explained below, UVA Medical

Center excludes various items from that cost report in the UCC calculation. For 1998, DMAS used a contract auditor to audit the indigent cost report and there were *no* audit adjustments. Exhibit 5.

In short, UVA Medical Center has a good process for establishing indigency standards and for verifying that patients it names as indigent have met those standards.

This portion of UVA Medical Center's response has been deleted as it pertained to matters included in the draft report which are no longer contained in the final report.

This portion of UVA Medical Center's response has been deleted as it pertained to matters included in the draft report which are no longer contained in the final report.

4.4 Timing

The indigent care cost report includes charges from prior years' services and the draft report correctly notes that such charges have been included in UVA Medical Center's UCC calculation. There are two reasons for this. First, there are services furnished around the end of UVA Medical Center's fiscal year when it is virtually impossible to determine the indigence of

the patient prior to year end. Second, there can be delays, sometimes long delays, in obtaining from patients the information needed to verify indigence. While the indigence determination is pending, the patient is not included on the indigent care cost report and hence is not included in the UCC calculation. When the proof of income and assets is furnished, however, and an indigence determination is made, the account is included in the indigent care cost report.

The Draft Audit Report has looked at one side of the equation only. It has looked solely at the indigent care costs from prior years included in the audited years; the audit did not, however, look at the substantial indigent care costs reported subsequent to the audited years for services furnished in 1997 and 1998. UVA Medical Center believes that its approach was the logical, practical, and fair approach. In any event, if both sides of this issue are addressed together through elimination of prior year costs and inclusion of 1997 and 1998 costs reported in subsequent years, the results will be very similar as discussed in the following section.

4.5 Recasting of Indigent Care Data

UVA Medical Center has the ability to recast the indigent care data to exclude costs related to other years and to include costs for the audited years claimed in subsequent years. UVA Medical Center also has the ability on a patient-by-patient basis to identify whether there was any insurance. UVA Medical Center prefers to maintain the methodology that it has used and which has been accepted by DMAS, but if DMAS were to apply a different approach, UVA Medical Center could furnish the relevant data, and the effect over the years should be immaterial.

This portion of UVA Medical Center's response has been deleted as it pertained to matters included in the draft report which are no longer contained in the final report.

Pages 16 & 17 of UVA Medical Center's response have been deleted as they pertained to matters included in the draft report which are no longer contained in the final report.

VI. Conclusion

For the reasons set forth above, UVA Medical Center believes that the State plan is consistent with the federal statute and, as acknowledged in the Draft Audit Report, the UCC calculation is consistent with the State plan. Accordingly, no adjustments are appropriate.

Sincerely,

Larry L. Fitzgerald
Chief Financial Officer
UVA Medical Center

218960_3.DOC

Exhibit 2

From: [@dmas.state.va.us]
Sent: Tuesday, May 23, 2000 11:24 AM
To: @hscmail.mcc.virginia.edu
Subject: Re: FY98 cost report settlement

, DSH payments are limited to the sum of the hospital's Medicaid and uninsured losses. Per the as filed cost report, Medicaid losses were (10,743,213) + uninsurred losses of $58,132,062 = a net of $47,388,849.

Medicaid DSH payments were (1) Regular DSH of $6,605,157 and enhanced of $47,185,462 = a total of $53,791,006 or an overpayment of $6,402,157. This came about when we made the $35, 120,339 DSH payment for 99 and 00. The 99 payment made on 7/14/98 allocated $13,555,091 to SFY 98 and the 00 payment made on 7/12/99 allocated $33,620,371. Since I did not know that UVA would make an $11.5M profit on DRGs transition, I overallocated to much DSH to SFY 98. These numbers may change somewhat after desk audit. I will send up a fax of the as filed with the enhanced DSH numbers reflected.
We have approval to include physician cost in the uninsurred costs which should lessen the effect of the above.

>>> " " < @hscmail.mcc.virginia.edu> 05/23/00 11:03AM >>>

Regarding our conversation of earlier this morning, would you mind sending me some rough computations that I can take to and to discuss? I think I've got what we talked about, but it would help to get something from you spelled out. Thanks!!

I just talked to and he said he realized he needed to contact you on his way into work this morning, so I'm sure you'll be hearing from him soon!

Thanks a lot.

Exhibit 3

UVA - 1997

DSH Analysis for DMAS (FINAL)
For the year ended 6/30/97

1997

MEDICAID COSTS NOT ON THE COST REPORT

Costs of Medicaid Days over 21 not on cost report	1,021,144
Medicaid Unreimbursed Lab Costs	189,681
Medicaid Unreimbursed ER Costs	588,149
Medicaid Unreimbursed Peds TX Costs	73,479
Medcaid Non Covered Clinic Costs	254,321
Total Unreimbursed Costs not on Cost Report	2,126,774

INDIGENT CARE COSTS

I/P Va. Indigent Care Cost (net of copays) per the cost report	23,570,705
% of Costs Related to Uninsured Individuals	88.24%
Uninsured I/P Va. Indigent Costs	20,798,837

UVA -1777

O/P Va. Indigent Care Cost (net of copays) per the cost report	26,057,654
% of Costs Related to Uninsured Individuals	90.11%
Uninsured O/P Va Indigent Costs	23,479,998
I/P Non Va. Indigent Care Cost (net of copays) per the cost report	2,597,924
% of Costs Related to Uninsured Individuals	88.24%
Uninsured I/P Non Va. Indigent Costs	2,292,413
O/P Non Va. Indigent Care Cost (net of copays) per the cost report	997,553
% of Costs Related to Uninsured Individuals	90.11%
Uninsured Non Va. O/P Va Indigent Costs	898,874
BAD DEBT COSTS	
Bad Debt Write-offs	7,919,096
% Related to Uninsured Individuals	76.29%
Overall Ratio of costs to charges / Medicare cost report	75.41%

Bad Debt Costs of Uninsured Individuals	4,555,571

OTHER COSTS

Additional State Agency Charges not included in Bad Debt or Indigent Care computaions	2,650,029
Ratio of costs to charges per Medicare Cost report	75.41%
State Agency Additional Costs	1,998,256
Additional Self Pay Charges not included in Bad Debt or or Indigent care Computations	5,394,953
Ratio of costs to charges per Medicare Cost report	75.41%
Self Pay Additional Costs	4,068,067
Less: Self Pay Payments	5,394,953
Total Uinsured Unreimbursed Cost prior to EDSH	54,823,837 ✓
ESDH received from DMAS	35,120,339
Net Amount of Uninsured Unreimbursed Costs 97	19,703,498

54,823,857
~~104,980~~
~~54,928,617~~
54,823,837

Plus Indigent Care Cost of Physicians (HSF) -1997 10,302,524

Total uninsured Losses -1997 65,126,361

Exhibit 4

DSH Analysis for DMAS
For the Year Ended 6/30/98

1998

MEDICAID COSTS (Revised for FY 98 Amendment Issues @ 12/9/99)

Per Exhibit H of Cost Report	
Net Medicaid (Gain)/Loss	(11,532,376)
Unreimbursed OP Costs	789,162
Excess Costs over Net Payments	(10,743,214)
Costs of Medicaid Days over 21 not on cost report	3,372,978
Medicaid Unreimbursed Lab Costs	195,007
Medicaid Unreimbursed ER Costs	560,966
Medicaid Unreimbursed Peds TX Costs	(107,567)
Medcaid Non Covered Clinic Costs	214,263
Total Unreimbursed Costs not on Cost Report	4,235,647

INDIGENT CARE COSTS Per Report dated 11/12/98

I/P Va. Indigent Care Cost (net of copays) per the cost report	[redacted]
% of Costs Related to Uninsured Individuals	[redacted]
Uninsured I/P Va. Indigent Costs	16,587,712
O/P Va. Indigent Care Cost (net of copays) per the cost report	[redacted]
% of Costs Related to Uninsured Individuals	[redacted]
Uninsured O/P Va Indigent Costs	24,215,322
I/P Non Va. Indigent Care Cost (net of copays) per the cost report	[redacted]
% of Costs Related to Uninsured Individuals	89.63%
Uninsured I/P Non Va. Indigent Costs	2,787,041
O/P Non Va. Indigent Care Cost (net of copays) per the cost report	[redacted]
% of Costs Related to Uninsured Individuals	91.03%
Uninsured Non Va. O/P Va Indigent Costs	632,875

BAD DEBT COSTS

[redacted]

[redacted]

[redacted]

[redacted]

Bad Debt Write-offs	~~16,076,354~~
% Related to Uninsured Individuals	~~81.74%~~
Ratio of costs to charges per Medicare Cost report	~~71.06%~~
Bad Debt Costs of Uninsured Individuals	9,337,884

OTHER COSTS

Additional State Agency Charges not included in Bad Debt or Indigent Care computaions	~~2,362,789~~
Ratio of costs to charges per Medicare Cost report	71.06%
State Agency Additional Costs	1,679,053
Additional Self Pay Charges not included in Bad Debt o or Indigent care Computations	4,642,641
Ratio of costs to charges per Medicare Cost report	71.06%
Self Pay Additional Costs	3,299,169
Less: Self Pay Payments	~~4,642,641~~
Total Federal Cap on DSH FY 98	~~47,080,849~~ 58,132,062 (net of medicaid)
Regular DSH	6,601,504
Enhanced DSH	35,120,339
Total Federal DSH Payments FY 98	41,721,843

Plus Indigent Care Cost of Physicians (HSF) - 1998 8,814,198

Total Uninsured Losses - 1998 66,946,260

Exhibit 5

VIRGINIA MEDICAID ADJUSTMENT REPORT

UNIVERSITY OF VIRGINIA MEDICAL CENTER

PROVIDER NUMBER: 49-0009-0 FISCAL YEAR ENDED: 6/30/98

Adj. No.	Cost Report Reference: Schedule/ Form	Page	Line	Col.	Explanation of Adjustment	As Reported or Adjusted	Adjustment Increase (Decrease)	As Adjusted or As Revised
					No findings resulted in adjustments to the HCFA 2552 or Indigent Care cost reports.			